Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: MOHAMED BELAL ABDELAZIZ MAHMOUD SAAD**
Card No	**: I040-029-118737797-01**
Policy Holder	**: MOHAMED BELAL ABDELAZIZ MAHMOUD SAAD**
Payer Name	**: UNION INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 02-01-2025** To **01-01-2026**
Gender	**: Male**
Date Of Birth	**: 12-Nov-1995**
Patient's Tel No	**: 0588943992**

Service Date **:03-May-2025** **Network** : Green

Health Provider **:CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**

Doctor's Name **:AISHA**

Co-Insurance :

CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY	DENTAL
10% max	NIL	NIL	NIL LIMIT	NIL	10%	NA

Remarks :

☐ **Acute** ☐ **Pre-existing and chronic** ☐ **Maternity**

Chief Complaints : PT CAME WITH RIGHT SIDED EAR PAIN ALONG WITH FEELING OF EAR BLOCK **Duration:**
OE EAR IS RED FROM INSIDE ALONG WITH MILD BLOOD ACCUMULATION

Vitals: Temp : 36.6 Bp :140 Pulse :93 Resp :0

Clinical Findings:

Diagnosis: H66.004 - Ac suppr otitis media w/o spon rupt ear drum, recur, r ear,H92.01 - Otalgia, right ear, **Date of Onset :**03/14/2025

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 0355-103204-1681 - (CIPROFLOXACIN : 0.3%) EYE / EAR DROPS,0003-281701-0241 - (BENZOCAINE : 1.4%) (TYROTHRICIN : 0.05%) (ANTIPYRINE : 5%) (HEXYLRESORCINOL : 0.10%) EAR DROPS, **Estimated Cost :**

MEDICAL PRACTITIONER DECLARATION :

I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

PATIENT'S DECLARATION :

I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

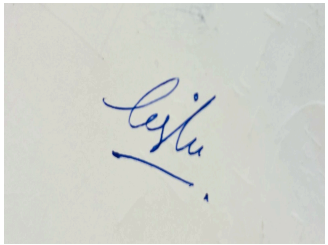
Dr's Name : AISHA

Stamp :

Dr. Aisha Umer
Physician- General Practitioner
DHA- 40131439-002
CITICARE MEDICAL CENTER
DUBAI - U.A.E

Patient 's signature{Parent if minor} :

Date : 03-May-2025

Signature : 

Date : 03-May-2025